

Medicaid Aged, Blind, or Disabled Programs Application Packet

This application is available in Spanish. Call 1-800-457-3659. Esta solicitud está disponible en español. Llame al 1-800-457-3659.

This packet provides information needed to assist you when applying for Wyoming Medicaid Aged, Blind, or Disabled Programs.

In addition to completing the Medicaid Application for Aged, Blind, or Disabled programs, an interview is required when applying for most programs. To schedule an interview, contact your local Department of Family Services (DFS) Field Service Office.

The following items are included in this packet:

- Application for Medicaid Aged, Blind, or Disabled Programs
- Medicaid Application Checklist for Aged, Blind, or Disabled Programs
- Medicaid Application Information for Aged, Blind, or Disabled Programs
- List of Department of Family Services Field Service Office Locations

Additional information on Wyoming Medicaid Long Term Care programs is available at:

• Wyoming Department of Health (WDH), Medicaid Eligibility: http://health.wyo.gov/EqualityCare

Appointment Date:	Benefit Specialist:
Appointment Time:	Phone Number:

*If you have any questions or problems making your appointment, contact me at the phone number above.

Medicaid Application Checklist for Aged, Blind, or Disabled Programs

Please provide verification for all items listed below, **if applicable**. Copies are okay, and a worker can help you make copies or assist with obtaining verifications, if needed. If you are married, verification of the same items will be required for your spouse. An interview will be required for most programs and additional items may be requested during the interview.

Personal Information

- U.S. Citizenship (U.S. Passport, WY Driver's License, Certificate of Naturalization or Birth Certificate)
- Identity (U.S. Passport, U.S. issued Driver's License or ID Card, or Certificate of Naturalization)
- Social Security Number or proof of application for Social Security Number
- Power of Attorney, Guardianship, or Conservator documents
- Alien Status, Permanent Resident Card or USCIS Record
- Health insurance card(s) including Medicare card

Income and Resource Information

- Income, including, but not limited to, pay stubs, self employment, social security, retirement/pension, unemployment benefits, veteran's benefits, interest, dividends or contributions
- Current (within last 30 days) statements for all bank accounts, savings, checking, CD or retirement accounts. This would include IRAs and 401(k) accounts
- Statements for all life insurance policies or annuities showing ownership, face value and current cash surrender value
- Copies of all stocks or bonds
- Vehicle titles or registrations for all licensed or unlicensed vehicles and verification of amounts owed
- Deeds for all real property, tax assessment, and verification of amounts owed
- Mineral rights owned and any current leases
- Prepaid funeral arrangements including funeral or burial accounts, mausoleums or plots
- Trust documents for any trusts for you or your spouse
- List of contents for safe deposit box
- Documentation of any transfers made by you, your spouse, or anyone acting on your behalf, in the past 60 months. This would
 include, but is not limited to gifts, transfers, or sale of properties

Liability Information

- Health insurance premiums
- Medical bills for the last 3 months (if any)

Medicaid Application Information for Aged, Blind, or Disabled Programs

Medicaid INFORMATION:

This application can be used to apply for Aged, Blind, or Disabled programs for individuals in need of professional care provided at home, in a nursing home, hospital or intermediate care facility. This application can be used for individuals who:

- Are aged, blind, or disabled
- Need help paying their Medicare premium
- Are in nursing homes or assisted living facilities
- Need nursing home level of care, but wish to remain in their home and receive specialized services
- Need Hospice care
- Need inpatient hospital care (for stays of 30 days or longer)
- Are employed and have a disability

This application can also be used to apply for the Prescription Drug Assistance Program (PDAP).

If you are receiving Supplemental Security Income (SSI) you are automatically eligible for Medicaid and do not need to complete an application. Contact your local DFS Field Service Office for more information.

If you do not have a Social Security Number (SSN), ask your eligibility worker about how to get one.

Eligibility is determined by DFS and is generally based on family income and sometimes resources and/or healthcare needs. If you have questions, or need help completing or understanding this application, contact your local DFS Field Service Office.

If you are only applying for a Medicaid Family and Children's program, including the Pregnant Women's program, please complete the Wyoming Healthcare Coverage Application, which can be found online at www.healthlink.wyo.gov.

If you need more information about Medicaid programs that are available, please visit: www.health.wyo.gov/EqualityCare.

RIGHTS AND RESPONSIBILITIES:

If you do not speak English, or if you are blind, hard of hearing or deaf, you can have interpretation services provided for you at no cost.

- Citizenship/Immigration Status Your signature certifies that the citizenship/immigration status is correct for each person applying. You do not have to give information about citizenship or immigration status of family members who are not applying for healthcare benefits. Your records will be kept confidential and will only be released for purposes authorized by federal and state law. Information you provide on this application will NOT be shared with the U.S. Citizenship and Immigration Services (USCIS) formerly known as Immigration and Naturalization Service (INS).
- Release of Medical Information The WDH or its representative must be able to obtain medical records from providers if necessary. Your signature authorizes your medical providers to release any medical records to the WDH or its representative.
- Social Security Numbers Social Security Numbers (SSNs) are required only for individuals who are applying for benefits. SSNs will be used to check the identity of household members to prevent duplicate participation. SSNs will also be used in computer matching, program reviews, and/or audits to make sure your household is eligible for this program. We will be comparing what you tell us with information on record with agencies such as the Department of Employment, Internal Revenue Service, Social Security Administration, Vital Statistics, Worker's Compensation, Child Support Enforcement, the Department of Revenue and Taxation, and the Department of Transportation. All persons in your home, who are applying for or receiving benefits, will be included in the computer matches. The information received may affect your eligibility and benefits. If you do not have an SSN for yourself or a household member, DFS can help you apply for one.
- Civil Rights None of the programs this application is used for will exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, sex, religion, political belief, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment. For further information about this policy contact your local DFS Field Service Office or the Office of Civil Rights at 1-800-368-1019.
- Administrative Hearings You may request a conference with your local DFS Field Service Office if you disagree with decisions made regarding this application. You may also request a conference with DFS Field Service Office due to any changes to your benefits. If you still don't agree after the conference, you may request an administrative hearing, which may be granted if requested within 90 days from the date the Notice of Adverse Action was generated. In order to receive continued benefits under the same program, you must request the administrative hearing within ten days of the date the adverse action was generated. You can request to have your local DFS Field Service Office help you arrange the conference and hearing. You may represent yourself at these meetings, or you may choose a friend, relative, lawyer, or other person to represent you. You will pay all legal charges if you hire a lawyer. If you want to discuss our decision or ask any questions about how an administrative hearing works, contact your local DFS Field Service Office. You may also call your local Legal Services Office to find out if free legal advice is available.

• **Reporting Responsibilities** – You are responsible for reporting changes to the information provided on this application within 10 days of identifying the change. Verification of these changes will be required. Changes in the following will need to be reported to DFS:

1) Income, 2) Resources, 3) Address, 4) Household Members, 5) Medical Insurance

If you expect any of the above items to change or they have already changed, call, write or complete a Change Report form and submit along with verification of the change.

- Medical Support If you receive Medicaid and also get money for the same medical bills, or the medical bills are paid by another insurance company or third party, you must give the money to the WDH. The state may collect from any potentially liable third party, insurance company, or from the proceeds of any court settlement or judgment for all medical bills. You are obligated to repay the state for 100% of the medical bills paid from any settlement or judgment prior to receiving any of the money or other benefits from the settlement or judgment.
- Estate Recovery The WDH will pursue recovery of medical care costs paid by the Medicaid program from the estate of a Medicaid recipient who was age 55 years or older when they received medical assistance or who was an inpatient in a medical institution when they received medical assistance.
- Verification of Application Information Any false statements you make on this application and failure on your part to report any change in circumstance which would affect your eligibility for payment from Wyoming Medicaid constitutes a crime. You could be prosecuted under Wyoming criminal laws for this crime. Your signature (or the signature of your representative) authorizes State and Federal officials to get and use computerized and other information about you to determine if you are eligible for benefits.

 Computer matches will be conducted against the information provided on your application. Identification of false information provided may occur through these computer matches. You must cooperate fully with state and local workers if your application is selected for review.
- Application Processing Your application will be approved or denied within 45 days from the date of application unless waiting for third party verification, in which case, the decision will be made within 60 days. If you are waiting for a disability determination, a decision will be made within 90 days from the date of application.

DO NOT risk losing your benefits or cause an overpayment by not notifying DFS of the change.

Department of Family Services Field Office Locations

Albany County DFS	Big Horn County DFS	Campbell County DFS	Carbon County DFS	Converse County DFS
2020 Grand Ave., Ste 400	616 2nd Ave., North	551 Running W Dr.	215 W Buffalo St., Ste 359	219 N Russell Ave.
Laramie WY 82070	Greybull WY 82426	Gillette WY 82716	Rawlins WY 82301	Douglas WY 82633
307-745-7324	307-765-9453	307-682-7277	307-328-0612	307-358-3138
Converse County DFS	Crook County DFS	Eastern Shoshone	Fremont County DFS	Fremont County DFS
925 W Birch St.	102 N 5th St.	42 Black Coal Rd.	201 N 4th St.	120 N 6th St., East
Glenrock WY 82637	Sundance WY 82729	Ft Washakie WY 82514	Lander WY 82520	Riverton WY 82501
307-436-9068	307-283-2014	307-332-0207	307-332-4038	307-856-6521
Goshen County DFS	Hot Springs County DFS	Johnson County DFS	Laramie County DFS	Lincoln County DFS
1618 E M St.	403 Big Horn St.	381 N Main St.	1510 E Pershing Blvd.	1100 Pine Ave.
Torrington WY 82240	Thermopolis WY 82443	Buffalo WY 82834	Cheyenne WY 82002	Kemmerer WY 83101
307-532-2191	307-864-2158	307-684-5513	307-777-7921	307-877-6670
Lincoln County DFS 631 N Washington St. Afton WY 83110 307-886-9232	Natrona County DFS 851 Werner Ct., Ste 200 Casper WY 82601 307-473-3900	Niobrara County DFS 905 S Main St. Lusk WY 82225 307-334-2153	Northern Arapahoe St. 325 Left Hand Ditch Rd. Unit 9334 Arapahoe WY 82510 307-857-1692	Park County DFS 1301 Rumsey Ave. Cody WY 82414 307-587-6246
Park County DFS	Platte County DFS	Sheridan County DFS	Sublette County DFS	Sweetwater County DFS
109 W 14th St.	1556 Progress Ct.	111 E Works St.	11 N Sublette Ave., B 1070	2451 Foothill Blvd., Ste 103
Powell WY 82435	Wheatland WY 82201	Sheridan WY 82801	Pinedale WY 82941	Rock Springs WY 82901
307-754-2245	307-322-3790	307-672-2404	307-367-4124	307-362-5630
Teton County DFS	Uinta County DFS	Uinta County DFS	Washakie County DFS	Weston County DFS
115 W Snow King Ave.	350 City View Dr., Ste 206	225 W Owen	1700 Robertson Ave.	2013 W Main St., Ste 101
Jackson WY	Evanston WY 82930	Mountain View WY 82939	Worland WY 82401	Newcastle WY 82701
307-733-7757	307-789-2756	307-786-4011	307-347-6181	307-746-4657

Medicaid Application for Aged, Blind, or Disabled Programs

Please read all questions carefully and complete each section to the best of your knowledge. Print your answers and sign the application using dark ink. You may have someone help you complete the application.

Once complete, take or mail the application to your local Department of Family Services (DFS) Field Service Office. An interview may be required to complete the application process. The address and phone number of your local DFS Field Service Office can be found on the list included in this packet, at http://dfsweb.state.wy.us/dfs/dfs-in-your-community.html, or by calling 1-800-457-3659.

Some information on this application must be verified for each person applying. Please see the checklist on page two (2) of this packet for a list of documents you should bring to your scheduled interview.

Applicant Information	:									
Last Name:			lame and Middle Initial:					Social Secu	urity Number: -	
Your Address:		City:			S	State: Zip Code		Zip Code:		
Mailing Address (If different):		City:			S	State	:	Zip Code:		
Home Phone Number:	(Cell Phone	e/Message Number:				Work Phone N	umber:		
()	())			()			
Email Address:			What is Your Preferred Language?				Place of Birth: City/State			
Birth Date:	Race and Ethnicity (Opt	tional):	nal): Sex:		Sex:	Sex:		Marital Stat	Marital Status:	
	☐ White ☐ American☐ Native Hawaiian or F☐ Hispanic or Latino ☐	Pacific Isla			□ Male	□Se			☐ Never Married ed ☐ Divorced ☐ Widowed	
Do you live in Wyoming or intend to live in Wyoming within the next 45 days? ☐ Yes ☐ No			Are you a US Citizen? If no, provide Permanent Resider Alien Registration #				Date of Entry into the US MM / DD / YYYY			
Do you have a legal (court-appointe	d) guardian and/or Pow	ver of Att							1 , == ,	

Tell Us About Your Spouse	, Child(ren), or P	arents Living in th	ne Household:		
Last Name, First Name, Middle Initial	Applying for benefits	Relationship to You?	Race & Ethnicity (Optional)	US Citizen?	
Last	_ □Yes □ No	☐ Spouse ☐ Child	□ White	□Yes □ No	
MI Month Day Year Date of Birth /	Sex	☐ Step-Child ☐ Sibling ☐ Parent ☐ Step-Parent ☐ Other:	 □ American Indian or Alaska Native □ Black □ Native Hawaiian or Pacific Islander □ Asian □ Hispanic or Latino 	If no, please provide: A #	
SSN:	City State		Other:	Month Day Year Date of Entry	
Last Name, First Name, Middle Initial	Applying for benefits	Relationship to You?	Race & Ethnicity (Optional)	US Citizen?	
First Month Day Year	Sex F	☐ Spouse ☐ Child ☐ Step-Child ☐ Sibling ☐ Parent	 □ White □ American Indian or Alaska Native □ Black □ Native Hawaiian or Pacific Islander □ Asian 	☐Yes ☐ No If no, please provide: A #	
Date of Birth	Place of Birth:	☐ Step-Parent ☐ Other:	☐ Hispanic or Latino ☐ Other:	(Alien Registration Number) and Month Day Year Date of Entry	
Last Name, First Name, Middle Initial	Applying for benefits	Relationship to You? □ Spouse	Race & Ethnicity (Optional)	US Citizen?	
First	Sex	☐ Child ☐ Step-Child ☐ Sibling ☐ Parent ☐ Step-Parent ☐ Other:	☐ White ☐ American Indian or Alaska Native ☐ Black ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Hispanic or Latino ☐ Other:	☐ Yes ☐ No If no, please provide: A #	
	City State			Date of Entry / /	

Note: Additional Household Members can be listed on the last page of this application.

Provide Medical and Insurance Inf	formation for Anyone in th	he Household A	pplying for Medicaid:	
Is anyone in your household pregnant?	es □ No		 	
Name of household member:		Is this their first pre	gnancy?	Due Date:
		☐Yes ☐ No		
Is there a household member applying for Med	licaid who is currently receiving or	entitled to Medicare?	□Yes □ No	
Name of household member:			Medicare Number:	
Name of household member:			Medicare Number:	
Is there a household member applying for Med ☐ Yes ☐ No	licaid who is currently covered by c	other insurance or has	other insurance available to them	?
Name of household member:	Group/Policy Number:		Type of Insurance Policy:	Amount of Monthly Premium:
Name of insurance company:	Date Insurance Began: /		☐ Long Term Care ☐ Disability ☐ Accident ☐ Health ☐ Other	\$
Name of household member:	Group/Policy Number:		Type of Insurance Policy:	Amount of Monthly Premium:
Name of insurance company:	Date Insurance Began: // MM / DD / YYYY		☐ Long Term Care ☐ Disability ☐ Accident ☐ Health ☐ Other	\$
Name of household member:	Group/Policy Number:		Type of Insurance Policy:	Amount of Monthly Premium:
Name of insurance company:	Date Insurance Began:		☐ Long Term Care ☐ Disability ☐ Accident ☐ Health ☐ Other	\$

Has anyone in the household, who is applying for Medicaid, been co ☐ Yes ☐ No	vered by health insurance or long term care ins	urance that ended in the last three (3) months?
Type of Insurance:	Date Insurance Ended:	For LTC Insurance, reason insurance ended:
☐ Health ☐ Long Term Care	//	
Type of Insurance:	Date Insurance Ended:	For LTC Insurance, reason insurance ended:
☐ Health ☐ Long Term Care	// 	
Does anyone in your household, who is applying for Medicaid, have ☐ Yes ☐ No	unpaid medical bills within three (3) months of	the date of application?
Name of Household Member:	Date(s) of Service:	
Name of Household Member:	Date(s) of Service:	
Are any of the household members applying for Medicaid currently ☐ Yes ☐ No	in a medical facility or long term care facility, or	do they plan to live in a long term care facility?
Type of Facility: Name of	Facility:	Entry Date:
☐ Hospital ☐ Nursing Home		MM / DD / YYYY
☐ Assisted Living Facility		
☐ Other		
Has anyone in your household served in the Armed Forces?	es 🗆 No	
Name of Household Member:		
Are you a dependent of a Veteran? ☐ Yes ☐ No		
Relationship to Veteran: Name of Vete	ran:	'eteran's Claim Number:
☐ Spouse ☐ Child ☐ Parent		

Туре	Y	N	Household Member(s)	Amount	Financial Institution/ Company Name	Account Number
Cash on Hand				\$		
Checking Account				\$		
Checking Account				\$		
Checking Account				\$		
Savings Account				\$		
Savings Account				\$		
Savings Account				\$		
Credit Union Account				\$		
Nursing Home Account				\$		
Certificate of Deposit				\$		
Stocks/Bonds/Annuities				\$		
RA/401K/Keogh/Pension Plan				\$		
Burial Funds/Trusts				\$		

Туре	Y	N	Household Member(s)	Amount	Financial Institution/ Company Name	Account Number
Pooled Trust				\$		
Special Needs Trust				\$		
Any Other Trust				\$		
Life Insurance				\$		
Other Resources				\$		

Туре	Y	N	Household Member	Value
Automobile				\$
Automobile				\$
Automobile				\$
Recreational Vehicle				\$
Crops/Equipment				\$
Tractors				\$
Livestock				\$
Property/Real Estate				\$
Life Estate				\$

Туре	Υ	N	Househ	Value	
Burial Space(s)					\$
Contract for Deed and/or Promissory Note					\$
Safety Deposit Box					\$
Other Resources					\$
Has anyone in the household sold, Examples: trusts, real estate, automobiles,			raded, or given away any item	ns of value in the past 60 months?	? □Yes □ No
Name of Household Member(s):	Tra	ate(s) Item aded/Giver		Item(s) Sold/Transferred/Traded/Giver	n Away:
Value:		nount(s) R ansfer:	eceived From Sale, Trade, or	Name of Person(s) the Item(s) was Sol	d/Transferred/Traded/Given Away to:
\$	\$				
Does anyone in your household have a Con	npanion	or Care C	ontract in place?		
□Yes □ No					
Does anyone give you money on a	month	nly basis	s to pay your expenses? \Box Ye	es 🗆 No	
Name of Person Providing Payment:			Amount of Monthly Paym \$	nent Provided:	
Has any household member receivetc.? □Yes □ No	ed or a	are they	expecting to receive a one-tir	me payment, i.e., a settlement, ir	nheritance, retroactive payment,
Name of Household Member:				When:	Amount:
					\$

Tell Us About Anyone in Your Household Who Has Income:									
Who has this income?	Is this Person a Full-Time Student?	Type of Income (Check all that apply)	Employer Name	Gross Total Income this Month (Income before taxes and deductions are taken out)	Claim #s (Enter all that apply)				
Last	□ Yes □ No	□ Self-Employment □ Wages □ Worker's Comp □ Unemployment □ Trust Fund Monies		\$					
First	If Yes, Grade:	□ Frust Fund Monles □ Veteran's Benefits □ SSA/SSI □ Pension □ Other							
Last	□ Yes □ No	□ Self-Employment □ Wages □ Worker's Comp □ Unemployment		\$					
First	If Yes, Grade:	☐Trust Fund Monies ☐Veteran's Benefits ☐SSA/SSI ☐Pension ☐Other							
Last	□ Yes □ No	□Self-Employment □Wages□Worker's Comp □Unemployment		\$					
First	If Yes, Grade:	□Trust Fund Monies □Veteran's Benefits □SSA/SSI □Pension □Other							
Last	□ Yes □ No	□Self-Employment □Wages□Worker's Comp □Unemployment		\$					
First	If Yes, Grade:	□Trust Fund Monies □Veteran's Benefits □SSA/SSI □Pension □Other							

Complete this section if you are assisting someone else with thi	Relationship:
Name.	☐ Child ☐ Spouse ☐ Sibling ☐ Friend ☐ Guardian ☐ Power of Attorney
	□ Other
Phone Number:	Address:
()	
Applicant or Authorized Representative's Statement of Understanding a	nd Agreement - I do allow any person having this information about me
or other household members to give any requested information, including c	confidential information, to any authorized agent of the State of Wyoming
or the federal government. This information will be used for the purpose of	determining eligibility for the programs for which I am applying. I also
agree to provide information necessary to verify any statement given on thi	3 3 , , 3
all officials of the State of Wyoming in investigations and prosecution of acti	
this authorization is as valid as the original.	
I certify that the information given on this form is true and correct. I realize i	if I give information that is not true OR if I withhold information, I can
be lawfully punished for fraud or perjury. I have also read and understand th	e Rights and Responsibilities listed at the beginning of this application. I
declare the identity of minors named on this form to be true and correct.	
Signature of Applicant or	
Authorized Representative:	Date
Cianatura of Fliaihilitus Markor	Data
Signature of Eligibility Worker:	Date
Please feel free to use the back of this page for additional information or co	mments.

Please use this space if you need additional room to answer questions from the application. If you need additional space please attach a separate page. Please be sure to write the question number next to the response. Please use this space for additional comments or if you have any additional information you would like to include.	